NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

Guidelines
for Programme Managers on Community Action for Health

Guidelines for Programme Managers on Community Action for Health

NATIONAL HEALTH MISSION

राष्ट्रीय स्वास्थ्य मिशन

Acknowledgements

These guidelines are based on the tool used in over 1,600 villages and 300 facilities in the first phase of community monitoring from 2007 to 2009. The guidelines were reviewed by a sub-group comprising representatives of civil society organisations, the Advisory Group on Community Action, the National Health Systems Resource Centre and the Ministry of Health and Family Welfare.

We acknowledge our sincere gratitude to Mr Manoj Jhalani, Joint Secretary (Policy) and Ms Limatula Yaden, Director, National Health Mission, Ministry of Health and Family Welfare, and the AGCA members for their guidance.

C.K. Mishra, IAS
Additional Secretary &
Mission Director, NHM
Telefax : 23061066, 23063809
E-mail : asmd-mohfw@nic.in

भारत सरकार
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
निर्माण भवन, नई दिल्ली - 110011
Government of India
Ministry of Health & Family Welfare
Nirman Bhavan, New Delhi - 110011

Message

Communitization has been envisaged as one of the five main approaches under the National Health Mission (NHM). The Mission seeks to provide universal access to equitable, affordable and quality health care which is accountable and at the same time responsive to the needs of the people. The inclusion of community based monitoring, now called Community Action for Health, as one of the three processes within the accountability framework is a clear reflection of the Mission's commitment to community participation. The Advisory Group on Community Action (AGCA) was constituted by the Ministry of Health and Family Welfare in 2005, almost immediately after the launch of the Mission. The AGCA comprises public health and civil society experts and is mandated to advise the government on community action under NHM. Population Foundation of India (PFI) hosts the AGCA Secretariat.

The first phase of the community based monitoring of health services was initiated under the guidance of the AGCA with support from the Ministry of Health and Family Welfare (MoHFW). This phase was implemented in nine states-Assam, Chhattisgarh, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Odisha, Rajasthan and Tamil Nadu between 2007 and 2009. An external evaluation of the initiative showed very positive results and recommended scaling it up to all states. Subsequently, states have been including community based monitoring as a component of the state NHM programme implementation plans (PIPs).

These guidelines for programme managers have been developed based on the cumulative experience and understanding of all those working at national, state, district and sub-district levels. The guidelines include a comprehensive set of principles for establishing and strengthening Community Action for Health as also the institutional mechanisms and processes required for implementation. The document has been developed in consultation with various civil society organisations under the guidance of the AGCA members.

I hope that the states will use these guidelines widely and guide programme managers at state, district and sub-district levels in adapting the Community Action for Health processes to the state specific contexts for successful scale-up of the implementation of Community Action for Health.

C K Mishra

October 29, 2014

Manoj Jhalani, IAS
Joint Secretary
Telefax : 23063687
E-mail : manoj.jhalani@nic.in

सत्यमेव जयते

भारत सरकार
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
निर्माण भवन, नई दिल्ली - 110011
Government of India
Ministry of Health & Family Welfare
Nirman Bhavan, New Delhi - 110011

Foreword

The National Rural Health Mission, launched almost a decade ago, viewed community processes as central to its major strategies. I am happy to note that the Advisory Group on Community Action (AGCA) supported through the NRHM, and now the National Health Mission, has been able to demonstrate significant achievements in this area. The Guidelines for Programme Managers and the User Manual for community and facility committees are important outcomes of their work. I commend the commitment and guidance of the AGCA members and the hard work of the Secretariat in enabling the development of the guidelines, manual and the accompanying tool.

Engaging civil society, community and the health system and bringing them on a common platform is no easy task. My involvement in various AGCA processes validates this impression. The Guidelines, User Manual and the tool reflect the dedicated involvement of the AGCA members. Community Action for Health is an evolving process. With renewed commitment from the MoHFW, 22 States/Union Territories have initiated the process of rolling out the Community Action for Health component by including it in the State Programme Implementation Plans (PIPs) with support from the AGCA. However, consistent and sustained efforts are needed by the States to integrate and institutionalize the Community Action for Health conponent to cover the entire country and fulfil the goals of NHM.

We urge the state governments to translate and adapt these Guidelines and User Manual and its tool as appropriate to state contexts. We also encourage the states to partner with NGOs in order to rapidly scale-up Community Action for Health and to ensure civil society representation in this important endeavour.

October 29, 2014

Manoj Jhalani
Joint Secretary, Policy

Structure of the Guidelines

The Guidelines are structured as follows: Section One includes lessons from the pilot phase and an overview of the key features of the process. Section Two discusses the institutional mechanisms required to implement Community Action for Health, including roles and responsibilities of different stakeholders. Section Three describes the application of the toolkit. Section Four depicts the various levels of the planning process once the report card is generated, including feedback mechanisms and inter-sectoral convergence. Section Five focuses on the process involved for capacity building of support structures at various levels.

The programme guidelines draw on references which can be accessed at *http://nrhm.gov.in/nhm/nrhm/guidelines/nrhm-guidelines.html.* The guidelines are intended for the use of programme managers responsible for community process interventions at state, district and block levels and non government organisations (NGOs) who partner with the state in the process of Community Action for Health.

Acronyms

AGCA	Advisory Group on Community Action
AF	ASHA Facilitator
ANM	Auxiliary Nurse Midwife
ANC	Antenatal Care
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
AWC	Anganwadi Centre
BCM	Block Community Mobiliser
CBMP	Community Based Monitoring and Planning
CBO	Community Based Organisation
CMO	Chief Medical Officer
CMHO	Chief Medical Health Officer
CHC	Community Health Centre
ICDS	Integrated Child Development Services
NGO	Non Government Organisation
MoHFW	Ministry of Health and Family Welfare
MTA	Mother Teacher Association
NHM	National Health Mission
PFI	Population Foundation of India
PTA	Parent Teacher Association
PHC	Primary Health Centre
PMC	Planning and Monitoring Committees
RKS	Rogi Kalyan Samiti
SC	Sub Centre
VHND	Village Health Nutrition Day
VHSNC	Village Health, Sanitation and Nutrition Committees

Contents

I Section

Background, Components and Key Features

Community Action for Health, earlier known as Community Based Monitoring and Planning (CBMP) of health services, is a key strategy under the National Health Mission (NHM). It is envisaged as an important pillar of NHM's Accountability Framework in order to ensure that the services reach those for whom they are intended. The accountability framework proposed in the NRHM is a three-pronged process that includes internal monitoring, periodic surveys and studies and community based monitoring. Community monitoring is also seen as an important aspect of promoting community led action in the field of health. The provision for Monitoring and Planning Committees has been made at the Primary Health Centre, Block, District and State levels. The adoption of a comprehensive framework for community-based monitoring and planning at various levels places people at the centre of the process of regularly assessing whether the health needs and rights of the community are being fulfilled.

In 2005, the Ministry of Health and Family Welfare (MoHFW) constituted an Advisory Group on Community Action (AGCA) under the National Rural Health Mission (NRHM). This group was mandated to advise NRHM on community action including community monitoring initiatives. It comprises eminent public health professionals and civil society representatives. The Population Foundation of India (PFI) hosts the Secretariat of the AGCA.

A pilot phase of community based monitoring of health services was implemented under the guidance of the AGCA in nine states covering 36 districts and 1600 villages. The initiative was supported by the MoHFW. The processes included capacity building of Planning and Monitoring Committees (PMCs) and Village Health, Sanitation and Nutrition Committees (VHSNCs) to undertake community enquiry and assessment of a set of services provided through outreach and various facilities. An external evaluation of the pilot demonstrated positive outcomes of the CBMP process towards improving health services under NRHM[1]. Key findings included:

[1]Population Foundation of India 2010. Reviving Hopes Realizing Rights: A Report on First Phase of Community Monitoring under NRHM. New Delhi

- Increased awareness among communities for health service provision and health entitlements.
- Greater community involvement and support in local planning resulting in reduction of service delivery constraints of front line health workers.
- Significant increase in utilization of village-level untied funds based on local priorities identified by VHSNCs.
- Improvements in the availability, range and quality of services, especially during the Village Health Nutrition Day (VHND) following regular review and dialogue.
- Significant improvements in timely and full disbursals of the Janani Suraksha Yojana (JSY) benefits and a considerable reduction in the number of providers demanding informal payments.

Community Action for Health, earlier known as Community Based Monitoring and Planning (CBMP) of health services, is a key strategy under the National Health Mission (NHM). It is envisaged as an important pillar of NHM's Accountability Framework

- A platform for dialogue with service providers through public sharing of health report cards and paving the way for corrective action and planning. Actions included reduction in the practice of prescribing medicines from private shops, provision of unavailable essential medicines through Rogi Kalyan Samiti (RKS) funds.
- Increase in the number of people availing services from primary health centres in some areas.
- Display and provision of Citizen's Health Charter, suggestion boxes, list and availability of essential medicines at facilities.
- Operationalization of non-functional laboratory facilities in some districts.
- Involvement of adolescents (12-17 years of age) in VHSNCs of some blocks to raise issues related to children and adolescents in the meetings.
- Approval of a mobile medical unit under one of the PHCs on community's demand.

Community Action for Health ensures that people's health rights are being met through a process of active engagement of the community in assessing the availability and quality of the services they are entitled to.

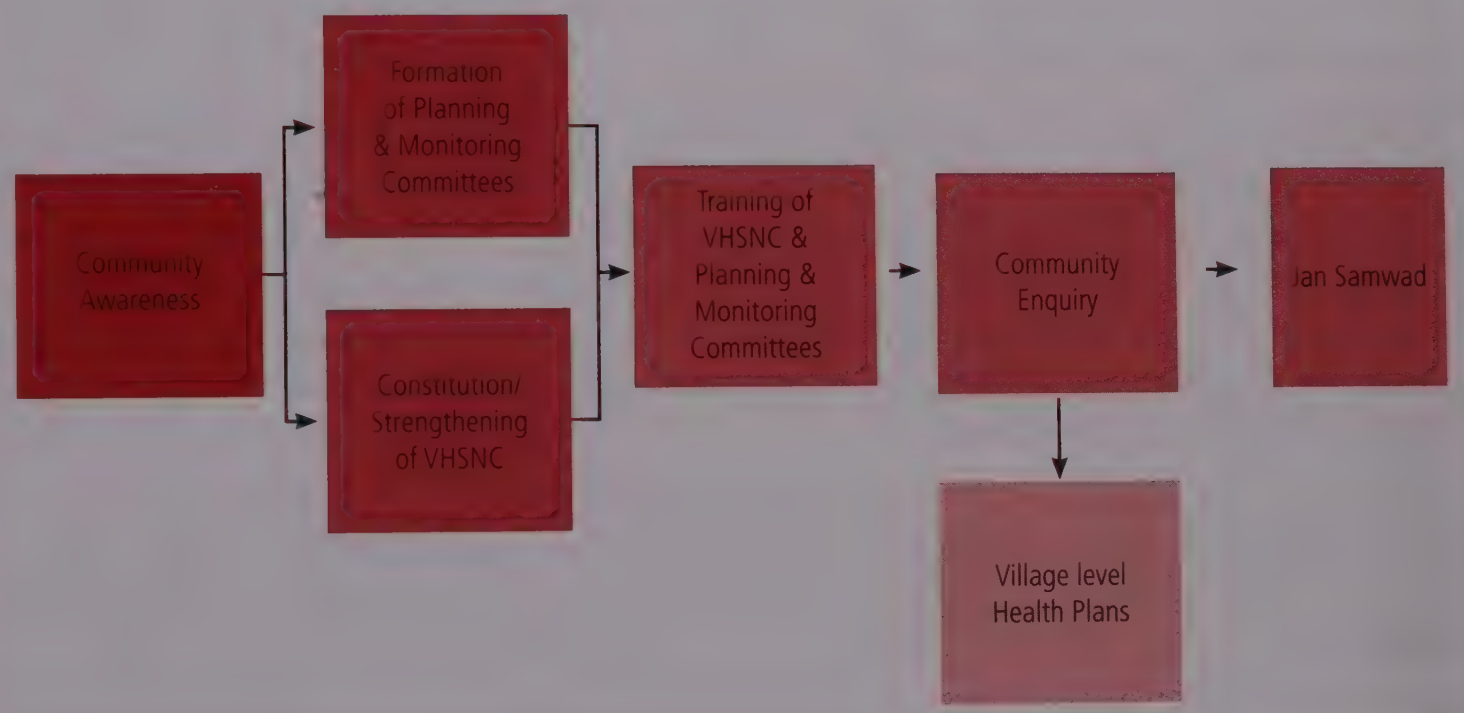
Community Action for Health Process

The Community Action for Health process has the following essential components:

- Creating community awareness on NHM entitlements, roles and responsibilities of the service providers
- Formation and strengthening of Planning and Monitoring Committees (PMCs) at Primary Health Centre (PHC), block, district and state levels
- Strengthening of Village Health, Nutrition and Sanitation Committees (VHSNCs) at the village/ Gram Panchayat level to undertake the Community Action for Health process
- Training of VHSNC and PMC members at all levels

- Undertaking community enquiry and facility assessment on a biannual basis using structured tools in order to monitor community and facility based health services
- Using periodic Jan Samwad (Public Dialogue) for advocacy with key stakeholders to highlight gaps and find solutions
- Developing village, block and district health plans for aggregation into state-level planning processes.

Figure 1: Steps of the Community Action for Health Process



Key Features

1. The process of community action ideally needs to be facilitated by an agency with a degree of independence from the health care delivery system. At state, district and block levels there is a need for an agency, independent from the health department with a functional role in implementation, and not merely an advisory role. This agency will also play an advocacy role if response from the system does not emerge.

2. Such implementation agencies need to be supported by officials working in the health system, and the process needs to be mentored by multi-stakeholder advisory bodies at district and state levels. Nodal civil society organizations/consortia or group of civil society organizations with demonstrated capacity and credibility are needed to support this process. The roles of the nodal civil society organization/group at each level will be to undertake capacity building of members of the planning bodies, facilitate implementation of key activities and undertake advocacy.

3. Planning & monitoring committees (PMCs) at PHC, block, district and state levels need to be set up to enable planning based on feedback from each successive level. Where MPCs are not formed, regular review meetings at block and district levels may be considered, and existing mechanisms may be used to feed into the planning process.

4. Oversight of implementation will be through multi-stakeholder advisory groups at district and state levels – State and District Mentoring and Advisory Groups for Community Action. These could either be established independently from the State ASHA Mentoring Group which provides support to community process interventions in the state, or be part of the existing structures.

5. Spaces for multi-stakeholder dialogue are necessary. Such multi-stakeholder involvement includes health officials and providers, Panchayati Raj Institution members, community members and civil society groups. These include existing bodies at local level (VHSNC and Rogi Kalyan Samiti) as well as additional bodies at higher levels. Co-convenors of dialogue bodies may be from facilitating civil society organisations to ensure regularity. Such meetings should be held at least once a quarter. Gaps highlighted through community feedback process should be discussed and follow up action ensured.

6. Dialogue spaces must encompass inter-sectoral representatives and become a fulcrum of integrated action on various social determinants of health. The multi-stakeholder committee at each level needs to have representation from other sectors to ensure necessary expertise and capacity for action on social determinants. At the block and district levels, officials from the general administration, ICDS, water supply and sanitation and other relevant departments along with Panchayati Raj representatives should be on the multi-stakeholder committees (such as monitoring and planning committees). Training and capacity building of all participants for effective inter-sectoral action (moving beyond vertical, fragmented action) needs to be planned.

7. There needs to be a clear commitment of the health system to respond to the issues emerging from the monitoring and planning process. Otherwise, it is unethical and wasteful to set such processes in motion. Community needs that emerge from planning sessions could be supported by governments, other than through the use of untied funds.

8. Community Action for Health processes must be operationalized simultaneously at all levels of the health system with effective linkages between them. Community action for health cannot be effectively operationalised only through community-
level activities.

9. Unresolved issues must be systematically raised and discussed at the next level in the health system. Decisions taken at various levels need to be fed back to the lower levels through instituting feedback systems and regular Action Taken Reports.

10. The functioning of the programme should be actively supported by the ASHA support structures, and facilitate involvement of ASHAs in the Community Action for Health process. The VHSNC and RKS are integral to the mandate of Community Action for Health. These need to be activated, oriented and may have to be expanded to ensure active community representation. Structures established for support to the community interventions component, need to be facilitated by civil society organizations and actively incorporate community based suggestions.

There is a great diversity in states and districts in terms of training of members of VHSNCs and PMCs, support systems including partnerships with NGOs, and community awareness on entitlements. Therefore, each question in the formats is given a level. States have the discretion to customize the tool depending on the a) functionality of the health system (b) capacities and handholding by implementation organisations and (c) duration of implementation of the Community Action for Health programme. Three levels are identified based on a set of criteria. These levels are:

The Characteristics of the Regions:

LEVEL I

- ***Resources for capacity building:*** Training infrastructure in terms of a pool of trained resource persons as well as support structures for ASHAs, RKS etc is weak or absent.
- ***Presence of civil society organisations:*** Weak civil society organisations/ NGOs in the area.
- ***Status of the public health system:*** Remote and inaccessible areas where the public health system is weak in terms of infrastructure and manpower.

At this level, Community Action for Health will focus on availability of the core entitlements and basic quality aspects such as cleanliness, the behaviour of the health staff and display of OPD timings. In areas under this level, the Community Action for Health process will focus on building demand for service and highlighting the critical gaps in the availability of services so that the system can respond and fill these gaps.

LEVEL II

- ***Resources for capacity building:*** There are fairly well developed training resources in terms of infrastructure and a pool of trainers. The support structures for ASHAs and RKS exist, and are functional. While the training capacity is present, supportive supervision requires further strengthening.
- ***Presence of civil society:*** There is a strong civil society presence, with experience in community-level training but not yet optimally utilised by the district/state.
- ***Status of the public health system:*** There are adequate number of functional PHCs, moderate availability of human resources, trained and functional ASHAs, moderately regular organisation of VHSND and regular visits by ANMs.

At this level, in addition to aspects covered in Level-I, the Community Action for Health process will go beyond availability to focus on the quality of the services delivered. These will include counseling services, infection prevention and other protocols.

LEVEL III

- ***Resources for capacity building:*** There is an efficient and mature system of capacity building in terms of infrastructure, trained resource persons and manuals. There is adequate capacity for supportive supervision as well.
- ***Presence of civil society:*** Strong civil society organisations/NGOs are available and being used by the system for Community Action for Health.
- ***Status of the public health system:*** The region has trained and functional ASHAs, regular VHSND and visits by the ANM, functional PHCs and SCs, wide coverage of the Janani Suraksha Yojana and Janani Shishu Suraksha Karyakram. Overall the public health system is functional, efficient and service provision goes beyond Maternal and Child Health (MCH) services.

In addition to aspects covered in Level-I and Level-II, the Community Action for Health process at this level will be based on a broader definition of health – it will go beyond Maternal and Child Health and focus on educational components of the services.

II Section Institutional Structures and Composition

The composition of committees at different levels is given below:

Table 1. Structure and composition of different committees

Structure	Composition
State Level Planning & Monitoring Committee	■ 30% of total members to be elected representatives, belonging to the state legislative body (MLAs/MLCs) ■ 15% to be non-official members of district committees, by rotation from various districts of different regions of the state ■ 20% members to be representatives from the state health NGO coalitions working on health rights, involved in facilitating community based monitoring 25% members belong to the State Health Department. These would include the Secretary, Health and Family Welfare; Commissioner, Health; relevant officials from the Directorate of Health Services (including the NHM Mission Director) along with technical experts from the State Health System Resource Centre / Planning cell ■ 10% members to be officials of other related departments and programmes such as Women and Child Development, Water and Sanitation and Rural Development. *Chairperson:* One of the elected members (MLAs) *Executive Chairperson:* Secretary, Health and Family Welfare *Secretary:* One of the NGO/civil society representatives

District Level Planning & Monitoring Committee	■ 30% members to be representatives of the Zilla Parishad ■ 25% members to be district health officials, including the District Health Officer /Chief Medical Officer and Civil Surgeon or officials of equivalent designation ■ 15% members to be non-official representatives of block committees ■ 20% members to be representatives from NGOs/CBOs and people's organisations working on health rights and regularly involved in facilitating community based monitoring at other levels (PHC/block) in the district ■ 10% members to be representatives of Hospital Management Committees in the district *Chairperson:* A Zilla Parishad representative *Executive Chairperson:* CMO/CMHO/DHO or officer of an equivalent designation *Secretary:* One of the NGO / CBO representatives
Block Level Planning & Monitoring Committee	■ 30% members to be representatives of the Block Panchayat Samiti (Adhyaksha/Adhyakshika of the Block Panchayat Samiti or its members, with at least one woman ■ 20% members to be non-official representatives from the PHC health committees in the block, with annual rotation to enable representation from all PHCs over time ■ 20% members to be representatives from NGOs/CBOs and people's organisations working on community health and health rights in the block, and involved in facilitating monitoring of health services ■ 20% members to be officials such as the Block Medical Officer, the Block Development Officer, selected Medical Officers from PHCs of the block ■ 10% members to be representatives of the CHC-level Rogi Kalyan Samiti *Chairperson:* Block Panchayat Samiti representative *Executive Chairperson:* Block Medical Officer *Secretary:* One of the NGO/CBO representatives
PHC Planning & Monitoring Committee	■ 30% members to be representatives of Panchayat Institutions (Panchayat Samiti members from the PHC coverage area) ■ 20% members to be non-official representatives from the village health committees ■ 20% members to be representatives from NGOs/CBOs and people's organisations working on community health and health rights in the area covered by the PHC ■ 20% members to be health and nutrition care providers, including the Medical Officer – Primary Health Centre and at least one ANM working in the PHC area ■ 10% members to be from the PHC-level Rogi Kalyan Samiti *Chairperson:* Panchayat representatives, preferably Panchayat Samiti member from the PHC coverage area *Executive Chairperson:* Medical Officer of the PHC
Village Health Sanitation Nutrition Committee	■ Gram Panchayat members from the village ■ ASHA, Anganwadi Worker, ANM ■ Self Help Group Leader, Parent Teacher Association (PTA)/Mother Teacher Association (MTA) Secretary, village representative of a community based organisation working in the village, user-group representative *Chairperson:* Panchayat member (preferably woman or SC/ST member) *Convenor:* ASHA; where ASHA is not in position, it could be the Anganwadi worker of the village

Source: NRHM Framework for Implementation, 2005-2012

Table 2 - Roles and responsibilities of different stakeholders for community enquiry at different levels

Stakeholder	Role & Responsibility
State ASHA/Community Process Resource Centre/State Nodal NGO	■ Adapt the formats for community enquiry and facility surveys based on classification of levels (described in Section I under Key Features–Levels) ■ Translate the tool in local language ■ Identify and train a pool of state and district trainers
District Community Mobiliser/District Programme Manager/District Data Assistant/District NGO	■ Organise trainings of district trainers ■ Orient district planning and monitoring committees ■ Support in collection, collation and analysis of data from District Hospital/ Sub District Hospital/Community Health Centre ■ Facilitate Jan Samwad ■ Ensure follow up action on issues/gaps identified ■ Collate block level plans and use that to inform the District Plan
Block Medical Officer/Nodal Officer/ Block Community Mobiliser/ASHA Facilitators/Block NGO	■ Train VHSNC members ■ Support supervision to VHSNC & ASHA facilitators for preparation of report cards for facility and village levels ■ Mentor VHSNCs during their monthly meetings ■ Orient block planning and monitoring committees ■ Support in data collection, collation and analysis ■ Facilitate Jan Samwad ■ Ensure follow up action on issues/gap identified ■ Collate village level plans to develop block level plan
Village Health Sanitation Nutrition Committee/Members of PRI /SHGs/ CBOs	■ Conduct community enquiry and facility surveys facilitated by ASHA/ ASHA Facilitator/NGO/CBO ■ Prepare report card ■ Share report card with the community and identify issues for redressal at the PHC level. ■ Present denial of care/adverse outcome cases with service providers ■ Prepare village health plan based on the findings of the report card

III Section

The Community Action for Health Tool

The community enquiry and facility assessment processes require the structured tool to be used on a bi-annual basis. The tool is meant to enable community representatives understand service delivery standards, entitlements and service guarantees envisaged under the National Health Mission (NHM). This, in turn, leads to an informed interaction with health personnel on availability of staff, drugs, amenities, quality of services, and access to entitlements and services. Service guarantees under the National Health Mission as well as additional guarantees provided by the states are updated periodically and vary from one state to the other. It is critical to identify and list all guarantees within the state and use the information to mobilise communities and adapt the tool for community and facility enquiry. The AGCA Secretariat will work closely with the states in the identification and adaptation process.

The formats included in the Community Action for Health tool facilitate community members to collect and collate data on a range of issues. Experiences from different states in utilising pre-designed tool for community monitoring are summarised in Annexure I.

Components of the tool kit

There are two sets of formats—one for the Community and the other for the Health Facilities (See Table 3). The community-level formats cover entitlements under maternal and child health, adolescent programme, general health services in the village and ICDS. The facility formats cover services provided at different levels – the Sub Centre, Primary Health Centre (PHC), Community Health Centre (CHC) and the Anganwadi Centre (AWC). The formats and details on how they will be used are given in the companion User Manual for members of VHSNCs and PMCs at PHC, block and district levels.

Table 3- The tool with formats and methodology for data collection at the community and facility level

S. No.	Format	Methodology	Respondents	Number	Format Number
Community-level formats					
1	Maternal health services	Individual interview	Mothers who have delivered in the last six months	5 per village (3 from marginalised and 2 from general population)	Format No-1
2	ASHA support services	Individual interview	ASHA	All ASHAs in a village	Format No-2
3	Adolescent health services	Focus Group Discussion	In-school and Out- of-school children of 11-19 year age group (8 per group). mixed group	1 per village	Format No-3
4	Village health services	Focus Group Discussion	A mixed group of 10-12 men and women	2 per village (one from marginalised and one from the general population)	Format No-4
5	Child health services	Individual interview	Mothers of children aged 0-2 years	5 per village (3 from marginalised and 2 from general population)	Format No-5
6	ICDS services	Focus Group Discussion	Mothers of children in the age group of 0-6 years	1 per village (one more group discussion to be conducted if there is a marginalised group)	Format No-6
7	Anganwadi Centre (AWC)	Individual interview/ Observation	AWW	1 per AWC	Format No-7
8	Mid day meal and school health programme	Focus Group Discussion	5-10 students (6-14 years)	1 per school	Format No-8
Facility-level formats					
9	Sub Centre	Individual Interview/ Observation	ANM	1 per Sub Centre	Format No-9*
10	Primary Health Centre (PHC)	Individual interview/ Observation	Medical Officer	1 per PHC	Format No-10*
11	Community Health Centre (CHC)	Individual interview/ Observation	Senior medical staff	1 per CHC	Format No-11
12	Exit Interview at facility	Individual interview	Patient/attendant	5 per facility—include at least three women	Format No-12

As per the Guidelines for Community Processes 2013, Ministry of Health and Family Welfare, Government of India

How to use the tool

The tool is a set of formats that comprise questions on various services and entitlements at the community and facility levels. The community feedback on services is obtained through individual interviews and Focus Group Discussions.

The community level formats will be administered by VHSNC members, whereas the facility level formats will be administered by members of the PMCs of the respective facility at each level. For each question, response is coded as follows:
Good–Green
Average–Yellow
Poor–Red

While conducting individual interviews, the members of VHSNC/PMC will record by placing a tick mark against the appropriate color box based on the response. In a group interview, members should be encouraged to decide collectively on the response regarding performance. The rankings are validated in a larger community-level meeting.

The enquiry should be conducted on a bi-annual basis. The timing of the enquiry should preferably be synchronized with the preparation of the Programme Implementation Plan (PIP) process. This would enable inputs from the CBMP/Community Action for Health process to be incorporated into the PIP[2].

Compilation of Village and Facility Level Report Card

The data collected through the process of such enquiry would be collated as follows:

- Village Health Report Card (the outline is in Table 5)
- Facility Report Card (the outline is in Table 6)

The collation of data will be done by VHSNC or Planning and Monitoring Committee members based on the number of boxes of different colours that have been ticked. The scores derived from the formats for different services will be collated and presented in a Report Card (see Table 5 & 6). The collation will be done on the basis of the criteria given in Table 4.

Table 4- Collation criteria

Criterion	Final color
Number of boxes ticked GREEN is more than 75%	GREEN
Between 50 to 74% boxes have been tickmarked GREEN; Or If number of GREEN boxes are less than 50%, but the total number of GREEN and YELLOW boxes are more than those ticked RED	YELLOW
The total number of GREEN and YELLOW boxes are less than the number of RED	RED

After the report card has been filled in for each village; these are collated as cumulative report cards at PHC, block and district levels. A similar process is followed for facility report cards.

---

[2] *The main rationale behind this is to have a balance between regular monitoring, planning and follow up activities that will sustain the community's interest in the process versus giving the system time to respond to the issues brought up by the community. The key issue is for the process to be timed in such a way that the plans that emerge from the process are able to feed into the district and state processes of evolving PIPs.*

Table 5- Village Health Report Card

S.No	Sub -Tool/issue	Good	Average	Poor
1	**Maternal health services**			
	Antenatal care			
	Delivery			
	Post natal care			
	Family planning			
	Janani Suraksha Yojna (JSY) entitlement			
	Janani Shishu Suraksha Karyakram (JSSK)			
2	**Adolescent health services**			
3	**ASHA support services**			
4	**General health services**			
	Quality of care			
	Disease surveillance			
	Curative services			
	Untied fund			
5	**Child health services**			
	Immunisation			
	Childhood illness			
6	**ICDS services**			
	Nutritional guarantees			
	Growth monitoring			
	Referral services			
	Other services			
	Participation of community			
	Discrimination			
7	**Mid-day meal & school health**			
	Mid-day meal services			
	School health			
8	**Perception of ASHA functioning**[3]			

[3] *It may be noted that perception of ASHA functioning will be captured from maternal health, adolescent health, general health and child health service formats*

Table 6- Facility Report Card

S.No	Tool/issue	Good	Average	Poor
1.	**Community Health Centres (CHC)**			
	Maternal health services			
	Family planning services			
	Curative services			
	Outreach services			
	Infrastructure			
	Availability of drugs and non-medical supplies			
	Human resources			
	Accountability			
	Maternal and Infant Death Review			
2.	**Primary Health Centres (PHC)**			
	Availability of infrastructure			
	Availability of staff			
	General services			
	Availability of medicines			
	Availability of curative services			
	Availability of reproductive and maternal health services			
	Child care & immunisation services			
	Laboratory & epidemic management services			
3.	**Sub Centre**			
	Availability of staff			
	Availability of infrastructure			
	Availability of services			
4.	**Quality of Care (Exit interview)**			

IV Section

Sharing of Report Cards and Follow-up Process

After the preparation of community and facility report cards, a meeting is to be organised by the VHSNC at the Gram Sabha level. All residents, including members of community based organisations and Self Help Groups, the ASHA, ANM and AWW need to be present. The VHSNC Chairperson will share the findings of the report cards, discuss gaps areas and identify the steps for corrective action. This is then formulated as a plan. A draft template for the plan is provided in Table 7.

Plan for follow up:

- The locally developed action plan needs to be followed up at the village level. This can be done during the monthly meeting of the VHSNC.
- The issues not resolved at the village level would be taken up at the PHC level for resolution and included in the block level plan.

Table 7- Planning Sheet

Gaps (marked as Red & Yellow in Report card)	Reasons for gaps	Possible Solution	Responsibility	Timeline	Support Required
a.					
b.					
C					

Some issues can be solved at the local level. However, some cannot be solved locally and need referral to the next level. For example-

(a) *Specific gaps in local service delivery* – Issues such as irregular visits by the ANM, limited package of services at VHND, not reaching all women and children in the village, irregular availability of food at the AWC, etc, can be solved at the field level itself.

(b) *Problems specific to infrastructure /drug /equipment related issues* like sub centres in poor condition, BP apparatus not functional would entail minor funding, which can be sanctioned from the untied funds. However, in case of major amounts involved such as for repair of building, allocation of drugs, the issue could be put into the Programme Implementation Plan.

Once the village level sharing meeting has been held, the next step is to share the PHC and block report cards (cumulative village report card and facility report card) at the Jan Samwad that is held at the block level.

Once the village level sharing meeting has been held, the next step is to share the PHC and block report cards (cumulative village report card and facility report card) at the Jan Samwad that is organised at the block level. Details about how to conduct a Jan Samwad are provided in the *User Manual*.

Feedback Mechanisms

Based on the feedback and information obtained from the report card, corrective measures can be taken. The following steps need to be followed –

- Sharing of the report cards and follow up action at various forums like meetings of VHSNCs, Gram Sabha, Planning and Monitoring Committees at PHC, block and district levels, Rogi Kalyan Samities and District Health Society.
- Triangulation of data, generated through this process, with HMIS and survey data by programme managers at block and district levels.
- Representation of departments such as Nutrition, Water and Sanitation, and Education in the PHC, block and district-level planning and monitoring committees as the tool also captures information related to their services.

V Section Capacity Building

The capacity building plan will be developed based on the structures that are finalised at the state level for rolling out Community Action for Health. Training will be conducted at multiple levels.

- A team of state trainers will be trained at the state level by the national AGCA secretariat.
- A team of trainers at the district level, drawn from the block level (three for each block), will be identified and trained by the state-level trainers
- The district-level trainers would conduct trainings for Block Community Mobiliser (BCM), ASHA facilitators and selected ASHAs at the sub district level.

> The basic level of implementation, would be the systematic application of the public service monitoring tool which is a part of the Community Processes Guidelines

- The district trainers would then conduct the training for a team of five members from every VHSNC supported by the BCM, ASHA facilitator (AF) and ASHA.

State and district trainers will be trained at the state training sites designated for ASHA and VHSNC training. Training for BCM, AF and ASHA would take place at sub district/ block levels. State and district trainers can be drawn from NGOs. The training can also be undertaken in partnership with credible NGOs.

There is a great diversity in states regarding the training of members of VHSNCs and PMCs, and support systems including partnerships with NGOs. The basic level of implementation be would be the systematic application

of the public service monitoring tool which is part of the Community Processes Guidelines. This tool is meant to be administered by the VHSNC with support from the ASHA and ASHA Facilitator. The application of the public service monitoring tool will serve as a learning platform for communities and the system. As states progressively strengthen the Community Action for Health component, they can include appropriate formats as listed in Table 3.

In remote and inaccessible areas with poor public health facilities, insufficient health workforce, poor training for ASHAs and VHSNCs, no credible NGOs/CBOs, fledging support systems for community processes, and evidence that entitlements and service guarantees are sporadically met, the Community Action for Health mechanisms would need to be gradually introduced. At this level, the purpose of Community Action for Health would be to build demand for services, and highlight critical gaps in their availability, so that the system can respond and take corrective action.

Annexure I

Some Examples of Community Action Programmes

Community Action for Health, Tamil Nadu

In the pilot phase, the Community Action for Health programme in Tamil Nadu was implemented by SOCHARA (Society for Community Health Awareness, Research and Action), and covered 446 panchayats of 14 blocks in five districts.

VHSNCs members were trained on the community enquiry tool. The information collected through the monitoring process was collated into a Panchayat-level Report Card and presented to the Gram Panchayat. VHSNC members monitored the facilities available at the Health Sub Centres and the Primary Health Centre once in six months. In addition, an exit interview was held at the Primary Health Centre. Patients coming to the facility were asked to put in a coloured token based on their level of satisfaction with the services – a green coloured token for satisfactory services and a red coloured one for unsatisfactory services. These were then collated in the presence of elected representatives and block/district level health officials, and the report presented to the medical officer in charge of the facility. Patients were also asked to write their feedback on pieces of paper that were used as a basis for planning improvements in the facility. In some districts, this exercise extended to cover taluk-level hospitals and the district hospital too. On Panchayat Health Planning Day (once every six months), the Panchayat Report Card was presented to the president, panchayat ward members and other community members. Health care providers, including the Village Health Nurse and PHC medical officer, were invited to this meeting. A discussion based on the coloured grades awarded to various services was held. The objective of the planning exercise was "to change Red to Green in six months". Out of the list of areas identified as needing improvement, two or three were chosen in consultation with everyone present, and plans were made to find solutions for the issues. These plans were filled into a format that spells out responsibilities and time frame.

Swasth Panchayat Yojana, Chhattisgarh

Under the Swasth Panchayat Yojana, monitoring of the village health status is done along a pre determined set of 29 questions, and a birth and death register is maintained. Based on this monitoring, two to three issues are identified for action every month, their causes analysed, possible solutions planned along with clear delineation of responsibilities and time frame. In addition, approximately 12-16 VHSNCs are brought together under one cluster and they meet once every month. This space is used to identify problems that are common to several villages that may require coordinated action by higher officials in various departments. In order to take the processes at the village and cluster level to the block, public dialogues or Swasth Panchayat Sammelans are held annually at the block level.

The State Health Resource Centre (SHRC) also conducts annual surveys (Swasth Panchayat surveys) that assess the health situation of each village and panchayat. The data is collected by Mitanin trainers on 10 indicators through house-to-house surveys at the hamlet level and hamlet-level meetings. In order to reduce bias, the Mitanin trainers do not carry out the survey in their own district. This information is filled into a panchayat-level score card that is then presented to the Sarpanch of the panchayat. This enables the Sarpanch to identify specific aspects that need to be improved. In addition, the hamlet-level data is centrally analysed to arrive at consolidated panchayat-level indicators and the

composite panchayat-level Health and Human Development Index. Panchayats are then ranked block-wise based on these indices and the top ranking panchayats are given cash awards to encourage good performance.

Community Based Planning and Monitoring Programme, Bihar

The Community Based Planning and Monitoring Programme (CBPM) is being implemented with support from the State Health Society, Bihar, and in partnership with civil society organisations under the National Rural Health Mission since May 2011. It covers 300 villages across five districts.

The Village Planning Monitoring Committee (VPMC) members monitor services provided on the Village Health Sanitation and Nutrition Day (VHSND). In addition, a pre-designed tool has been used by the VPMC members to monitor health services in specific pre-determined domains. This is collated into a report card at village and panchayat levels to arrive at a colour code that grades services as good (green), average (yellow) and poor (red). These report cards are then presented both at village and panchayat level meetings, and discussed with the community for possible improvements. These community-level enquiries are supplemented by facility surveys that assess the availability and quality of services at the sub health centre and primary health centre. In addition, as part of increasing engagement between the communities and the public health system, Jan Samwads - facilitated public dialogues between people, local governments and health care providers - are being held at block and PHc levels.

Monitoring of Maternity Homes, Karnataka

The Public Affairs Centre (PAC), Bengaluru has used innovative methods to monitor the quality of maternity services in Bengaluru's municipality-run health centres. In 2000, PAC undertook a Citizen Report Card survey of maternity homes. The survey showed poor quality of services and a high degree of corruption. As a follow up, in 2009, PAC along with its partner NGOs took up a repeat monitoring of the facilities to understand the current status of services provided.

The first round of Citizen Report Cards in 2010 covered 12 maternity homes in Bengaluru municipal area and included interviews with health care providers, users and the Board of Visitors (a forum of users). Data from the above interactions was centrally entered, analysed and collated to form the Citizen Report Card. The findings were then shared with the Bengaluru municipality authorities to advocate for change.

Following this, and based on interactions with users of these facilities, indicators for a Community Score Card were developed. These Community Score Cards were filled in three maternity homes, as a group exercise with users and the health care staff. The findings of the Community Score Cards were then discussed at an interface meeting that brought together the staff of the maternity homes, higher authorities from the Bengaluru municipality and users of the facility. This resulted in a discussion along with plans for action to improve the services.

Source: Excerpt from Unpublished Monograph -Community Action for Health Experiences, Learning and Challenges, Population Foundation of India

Community Based Monitoring and Planning in Maharashtra

The Community Based Monitoring and Planning (CBMP) process was implemented in maharashtra as a pilot in five districts during 2007-09. Currently, CBMP is being implemented in 13 districts, covering 37 blocks, 150 PHCs and 680 villages. Support for Advocacy and Training to Health Initiatives (SATHI) is the state nodal agency. About 25 civil society organizations (CSOs) are involved collaboratively in implementing the CBMP.

Community feedback/assessment of health services are compiled through data collection and preparation of report cards.

- The experience and feedback of community members are collected using specific tools– in-depth interview, focus group discussion, case studies and review of records.
- The report card has three colour codes on the basis of the status of implementation of various activities and delivery of services. (Green - 75=100% activities completed or services delivered; Yellow - 50=74% activities completed or services delivered; Red - 1=49% activities completed or services delivered).
- Data is collated and analysed at different levels so as to present in the Citizen Report Card (prepared at village, sub-centre and PHC levels).
- Planning and monitoring committees send periodic reports to the committees above their level to ensure action on issues which they cannot resolve.

For further information, please visit: http://www.nrhmcommunityaction.org/

Advisory Group on Community Action (AGCA)

Secretariat
Population Foundation of India
B-28 Qutab Institutional Area,
New Delhi- 110 016, INDIA
Telephone: + 91-11-43894100; Fax: +91-11-43894199
E-mail: info@populationfoundation.in
www.nrhmcommunityaction.org

National Health Mission
Ministry of Health and Family Welfare
Government of India
New Delhi